AMERICORPSBENEFITS
PLAN A INFORMATION SUMMARY

BCS Insurance Company

This benefit program is provided under group insurance policies issued by BCS Insurance Company. Plan A is designed to help you pay for eligible medical expenses you incur as a result of non-occupational accidents or sicknesses. The following information is a brief summary of important features of the insurance plan. Every effort has been made to ensure the accuracy of this plan information summary. It is not a contract. This plan information summary is not a legal document. Terms and conditions of coverage are set forth in the policy. In the event of a discrepancy, the policy would be the determining factor. You may obtain a copy of the policy from your AmeriCorps Grantee Organization or by sending a written request to **ASRM/AmeriCorpsBenefits, 509 South Lenola Road, Building #2, Moorestown, NJ 08057.**

The benefits, exclusions and limitations described below apply to the residents of most states, however state laws do vary. State laws may affect the plan, but these differences in laws generally do not reduce benefits.

MEDICAL EXPENSE BENEFITS

After satisfaction of a $100 deductible each coverage year, Plan A pays 80% of the usual and customary (U&C) charges incurred for most eligible medical expenses (outpatient prescription drugs are paid at 50%), up to a $3,600 maximum base benefit each coverage year. Once the coverage year maximum base benefit has been exhausted, Plan A pays 100% of the U&C charges incurred for most eligible medical expenses (outpatient prescription drugs are paid at 50%), up to a $50,000 coverage year maximum supplemental benefit. Supplemental benefits are payable only after the base benefit has been exhausted in each coverage year.

Benefits are payable, subject to any applicable limitation, for eligible medical expenses incurred while your coverage is in force. You must be under a doctor's care, and the treatment must be medically necessary for covered injury and sickness. No benefit will be paid for a charge that is incurred in connection with a particular accident or sickness if it is incurred more than one year after the date of the first covered loss for that accident or sickness.

ELIGIBLE MEDICAL EXPENSES

Eligible medical expenses are as follows: hospital room and board charges; charges for other hospital services (which include ancillary hospital charges for pharmacy, medical and surgical supplies and devices, laboratory and X-rays, and operating and recovery room); inpatient and outpatient doctors' charges; inpatient private-duty nursing charges; charges for inpatient specified therapies, including physiotherapy, acupuncture, and chiropractic services; charges for outpatient laboratory, diagnostic, and X-ray examinations; rental charges for durable medical equipment or the purchase of this equipment, whichever is less; charges for outpatient prescription drugs; charges for emergency professional ambulance service to the nearest hospital; and, charges for outpatient specified therapies (including physiotherapy, acupuncture, and chiropractic services) only if immediately following a hospital confinement or surgery for which benefits are paid under the plan.

LIMITS ON MEDICAL EXPENSE BENEFITS

Plan A benefits are limited as follows: 1) benefits for hospital room and board charges are limited to the U&C charges for semi-private accommodation or $600 per day, whichever is less; and, the U&C charges for confinement in an intensive care unit or $1,200 per day, whichever is less; 2) benefits for all eligible medical expenses incurred at a hospital as an inpatient, other than room and board charges, are limited to $2,000 per coverage year; 3) benefits for the treatment of substance abuse are payable for only one occurrence and are limited to: $10,000 per coverage year for eligible medical expenses incurred as an inpatient; and, $35 per visit and a 60-visit maximum when provided on an outpatient basis; 4) benefits for the treatment of mental illness are limited to: 45 days of confinement in a hospital and/or a non-hospital residential care facility per coverage year; and, 75% of U&C charges for eligible medical expenses for the first 40 outpatient visits, and 60% of U&C charges for any additional outpatient visits in that coverage year; 5) benefits for eligible medical expenses incurred due to elective termination of pregnancy are limited to $500; 6) benefits for eligible medical expenses incurred due to injury to sound natural teeth are limited to $250 per tooth per injury; 7) benefits for expenses incurred for emergency professional ambulance services to the nearest hospital are limited to $250; 8) benefits for specified therapies (including acupuncture, physiotherapy and chiropractic services) are limited to: $10,000 when provided on an inpatient basis; and, $1,000 when provided on an outpatient basis.

PRE-EXISTING CONDITIONS LIMITATION

A pre-existing condition means any condition for which you received medical treatment, diagnosis, care or advice within the 6-month period immediately preceding your effective date. During your first 12 months of coverage under the plan, benefits paid for eligible medical expenses due to pre-existing conditions will not exceed $1,000. The period during which coverage for pre-existing conditions is limited may be reduced by any creditable coverage you may have had with a previous insurance plan. Upon presentation of an acceptable certificate of creditable coverage, your pre-existing condition limitation waiting period will be reduced. Pregnancy is not subject to a pre-existing condition limitation.

FILING A CLAIM

When you have a claim, fill out a claim form completely and attach all applicable bills; send to **ASRM/AmeriCorpsBenefits, 509 South Lenola Road, Building #2, Moorestown, NJ 08057**. Medical benefits are paid directly to you, except when you assign your benefits to a provider, and will be mailed to you along with an Explanation of Benefits. If a claim is denied, you will be notified in writing of the reason for the denial. You will have 60 days to request a review of a denied claim.

A summary of Plan A exclusions can be found on the reverse side of this page.

EXCLUSIONS

Summary of what is not covered under the Medical Coverage

No benefits will be paid for loss caused by or resulting from: 1) intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane; 2) declared or undeclared war or any act thereof; 3) serving on full-time active duty in the Armed Forces of any country or international authority; 4) flying as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country; and 5) work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law, automobile medical payments or No-fault plans, public assistance programs, government plans, or any other valid and collectible group insurance.

In addition to the above exclusions, no benefits will be paid for: 1) eye examinations for glasses, any kind of eye glasses, or prescriptions therefore; 2) ear examinations or hearing aids; 3) treatment of teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, TMJ, dysfunction or skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; 4) cosmetic surgery, except cosmetic surgery that is needed for breast reconstruction following a mastectomy or as a result of an accident that happens while covered and that required treatment of the injury within 24 hours of the accident; 5) expenses used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered usual and customary; 6) services rendered by an immediate family member or services provided by the Grantee Organization; 7) injury or sickness resulting from use of alcohol or intoxicants, or any other drugs, unless as prescribed by a doctor; 8) treatment of congenital anomalies and conditions arising from them; 9) treatment of deviated nasal septum, including submucous resection and/or surgical correction; 10) expenses incurred in connection with an organ transplant; 11) care or treatment which is not medically necessary; and 12) care or advice for pre-existing conditions, except as expressly provided for under the policy.

TERMINATION OF COVERAGE

Your coverage will end on the earliest of: 1) the date you are no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid; or 2) any premium due date, if full payment for your coverage is not made within 31 days following the premium due date; or 3) the date that the policy terminates; or 4) the date you enter an armed service on full-time active duty.

CONTINUATION OF COVERAGE

If you become ineligible for coverage under the plan, you may choose to continue your coverage for up to 18 months. Your organization will provide you with a Continuation of Coverage Election Form when your coverage under the plan terminates. To continue your coverage, the completed election form and first premium payment must be received by ASRM within 60 days of your coverage termination date. You are responsible for paying the premium for your continued coverage. You will not be billed for subsequent premium payments and failure to make timely payments will result in the cancellation of the continued coverage.

AMERICORPS BENEFITS MEDICAL CLAIM FORM

BCS Insurance Company

PART A – CLAIM FORM INSTRUCTIONS

PLEASE PRINT

1. Read both sides of this form.
2. Completely fill out Sections B-F. (Part E is optional.)
3. Sign and date Section F.
4. Remember to provide your Social Security Number.
5. Attach all original itemized bills providing complete information on:
   - Doctor's Name and Address
   - Doctor's Tax Identification Number
   - Patient Name
   - Diagnosis Code ICD-9
   - Date of Service
   - Charges/Cost of each treatment
   - Procedure Codes CPT-4
   - Place of Service Code

Note: Itemized bills are NOT:
- Balance Due Statements
- Explanation of Benefits

6. If your medical provider sends your bill or claim to us, make sure an itemized bill is included.
7. Sign Section E if you want benefits paid to your medical provider.
8. If you have a Certificate of Creditable Coverage from your prior medical coverage please attach it to your completed Medical Claim Form and send it to:

   ASRM, Corp.
   509 South Lenola Road, Building #2
   Moorestown, NJ 08057
   800-359-7475

9. Make a copy of this form for your records.

PART B – INSURED PARTICIPANT INFORMATION

INSURED PARTICIPANT'S NAME (LAST, first, middle) ☐ Male ☐ Female

DATE of BIRTH MM / DD / YY

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER (☐☐☐) ☐☐☐-☐☐☐☐

ORGANIZATION NAME: Department of Ecology/WCC

ORGANIZATION GROUP NUMBER: AAX-00410

DOES THE INSURED PARTICIPANT HAVE OTHER HEALTH BENEFIT COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE INSURANCE PLAN OR PROGRAM NAME, THE POLICY OR GROUP NUMBER, AND THE EFFECTIVE DATE:

PART C – CLAIM INFORMATION

IS THE CLAIM FOR AN: ☐ ACCIDENT? OR ☐ ILLNESS?

IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ YES ☐ NO

WHEN DID THE ACCIDENT OR ILLNESS OCCUR? MM / DD / YY

PLEASE EXPLAIN WHAT YOU WERE TREATED FOR AND, IF TREATMENT WAS THE RESULT OF AN ACCIDENT, PROVIDE DETAILS OF WHEN, WHERE AND HOW THE ACCIDENT HAPPENED. **(If you need additional space, attach a sheet of paper to this form.)**

HAVE YOU HAD PRIOR TREATMENT FOR THIS CONDITION? ☐ YES ☐ NO

IF YOUR ANSWER IS YES, WHAT WAS THE DATE OF TREATMENT? MM / DD / YY

PART D – PRESCRIPTION DRUG INFORMATION

	NAME OF CURRENT MEDICATION(S)	CONDITION BEING TREATED
1.		
2.		
3.		

IF YOU HAVE MORE THAN THREE CURRENT MEDICATIONS, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER AND INCLUDE THE ABOVE REQUIRED INFORMATION.

PART E – ASSIGNMENT OF BENEFITS

TO BE COMPLETED BY THE INSURED. DO NOT SIGN THIS SECTION IF FEES HAVE ALREADY BEEN PAID TO YOUR PROVIDER.
I APPROVE THE PAYMENT OF BENEFITS TO THE DOCTOR OR OTHER MEDICAL PROVIDER SHOWN ON THE ITEMIZED BILL (Tax Identification Number included). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNATURE OF INSURED PARTICIPANT

DATE MM / DD / YY

PART F – AUTHORIZATION

INSTRUCTIONS: **THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE INSURED PARTICIPANT. IF THE INSURED PARTICIPANT IS UNABLE TO SIGN, THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE LEGAL GUARDIAN OR NEXT-OF-KIN.**

To all physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross-Blue Shield, self-insured and pre-paid health plans):

You are authorized to permit BCS Insurance Company, its Third Party Administrators, and its authorized representatives, to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition, including information relating to mental illness, drug or alcohol treatment, HIV (AIDS Virus), and disease of

_____
Print Name of Insured Participant

I understand the information obtained will only be used by BCS Insurance Company to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau, and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to BCS Insurance Company but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

SIGNED

DATE MM / DD / YY

RELATIONSHIP TO THE INSURED IF SIGNED BY OTHER THAN THE INSURED

IF SIGNED BY OTHER THAN THE INSURED, PLEASE PRINT NAME & ADDRESS AND INCLUDE GUARDIANSHIP PAPERS OR OTHER EVIDENCE OF LEGAL REPRESENTATION.

SEND TO: ASRM, Corp. • 509 South Lenola Road, Building #2 • Moorestown, NJ 08057
NOTE: Incomplete forms and the absence of itemized bills may delay the processing of your claim.

BCX 0001

FRAUD NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN INSURANCE APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE COMMITTING A CRIME ANY MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES.

The laws of some states require us to furnish you with the following notice:

California and Texas: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of loss or benefit is a crime punishable by fines or imprisonment, or both.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact, material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.